SEIZURE ACTION PLAN (SAP)

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Name: _____ Birth Date: _____

Address: _____ Phone: _____

Emergency Contact/Relationship: _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

How to respond to a seizure (check all that apply)

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify emergency contact
- ☐ Notify emergency contact at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First Aid for any seizure

- ☐ **STAY** calm, keep calm, begin timing seizure
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

When and What to do

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

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If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

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Care after seizure

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History: _____

Allergies: _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature: _____ Date _____

Provider Signature: _____ Date: _____

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